Los Alamos
Los Alamos National Laboratory
Los Alamos, New Mexico 87545

MEDICAL ILLNESS AND INJURY REPORT

Occupational Medicine Group (ESH-2)
667-7890 D421

Date:	
Time In:	

EMPLOYEE INFORMATION

NAME:			Z NO.:
GROUP:	MS:	WORK PHONE:	DATE OF BIRTH: ❒ MALE ❒ FEMALE
OCCUPATION:			EMPLOYER:
HOME ADDRESS:			
SUPERVISOR NAME:			PHONE:
SUPERVISOR'S MS:	SUPERVISOR NOTIFIED: ❒YES ❒NO DATE:_____		

ACCIDENT/INCIDENT HISTORY

DATE OF ACCIDENT/INCIDENT	TIME	AREA	BLDG	ROOM
DESCRIPTION OF EVENT:				
WITNESS(ES):				
EMPLOYEE SIGNATURE:	SUPERVISOR SIGNATURE:			

FAYE MILLER WILL SEE INFORMATION IN THESE TWO BOXES

ADMISSION HISTORY DATA

ALLERGIES:	LNMP:	PRESENTING HISTORY/COMPLAINT:
	LAST TETANUS:	
CURRENT MEDS:	T BP	Personal Information
	P R	
	PMD:	Interviewer's Signature:

MEDICAL EVALUATION

TIME: CHIEF COMPLAINT:

FAYE MILLER WILL SEE INFORMATION FROM THIS POINT FORWARD

SUBJECTIVE:

OBJECTIVE:

ASSESSMENT: ICD - 9

PLAN:

RECHECK
Date:
Time:

TESTS/TREATMENTS
X-RAY:
LAB:
ECG:
OTHER:
MEDS:
❒ SEE EXT. CARE SHEET

WORK RESTRICTIONS

❒ Limit work to _____ hours/day/week
❒ No overhead work
❒ No/Occ pushing/pulling
❒ No driving on official business
❒ No prolonged standing > _____ min
❒ No/Occ lifting over _____ lbs.
❒ Change positions frequently
❒ Ice/heat to (R) (L) back, neck, or _____ for _____ min _____ daily for _____ days
❒ No stairs, pole, ladder, or other climbing; or limit to _____
❒ Limit keyboard activity to: _____
❒ Limit work to _____ days/week
❒ No prolonged sitting > _____ min
❒ Use Crutches
❒ Sedentary (seated) only
❒ No/Occ bending/twisting
❒ Wear splint
❒ Limit walking to _____ ft or _____ minutes day
Other:

DISCHARGE INSTRUCTIONS

❒ Wound Care
❒ Back Injury
❒ Sprain/Strain
❒ Dermatitis
❒ Fracture
❒ Carpal Tunnel
❒ Head Injury
❒ Eye Problem
❒ Upper Resp Infection
❒ Gastroenteritis
❒ Puncture Wound
❒ Laceration
❒ Other

DISPOSITION

❒ Return to work - no restriction
❒ Return to work - see restrictions
❒ Sent home until _____
❒ Referred for followup with _____
❒ Transferred
by:
❒ Private vehicle
❒ Ambulance
to:
❒ LAMC ER
❒ PMD

I have had the diagnosis, treatment plan, discharge instructions, and any applicable work restrictions related to this clinic visit as noted above explained to me. I understand this information and my responsibilities for cooperation and followup in my own care as outlined by the ESH-2 health care provider.

EMPLOYEE'S SIGNATURE:

PROVIDER'S SIGNATURE:

Time Out:	

1-1a (1/31/96)